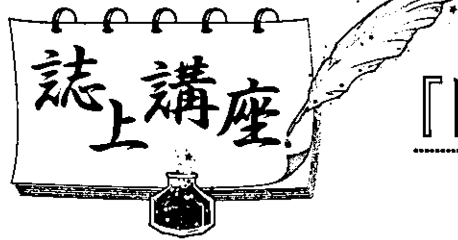

『開発と健康』

第1回

健康・開発・ジェンダー

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東南アジアの仏教国タイは、微笑みの国と呼ばれ、人々のやさしい笑顔が旅人の心を和ませてくれます。開発途上国とはいえ、近年の経済発展は目覚しく、ショッピング・モールで、携帯電話を手にした若者たちが群がっている様子は、日本のどこかで見られる風景と変わりありません。

東北タイは比較的貧しい地域です。一帯の農村部からコンケン市のような都市部に人々が流入してきて、市内を走る鉄道沿いの敷地に住みつきスラムを作っています。廃品回収などで生計を立てていますが、この仕事は重労働でよく怪我をするとのことです。

そこに住む、若い母親に会いました。スラムで生まれ育ち、なんとか小学校を卒業して、同じスラムに住む男性と結婚したとのことです。18才といいますが、顔には幼さが残り、14ー5歳にしか見えません。幼い子どもがいるのに、今また妊娠8ヶ月で、ようやく昨日から廃品回収の仕事を休むことにしたそうです。働きに出ていたため、上の子には母乳を与えなかったらしいです。

この若い女性の状況をどのように考えるべきでしょうか。確かに苛酷な生活です。貧しさゆえに、十分な教育も受けられず、なんの保障もない重労働に従事し、若くして次々に出産、子どもの健康や栄養にも十分配慮できません。経済発展につれて豊かになった人々がいる一方で、同じ国の中にこうした貧しい人々がいるという、大きな格差が存在します。

他方、この女性は比較的恵まれているとの見方もあります。

もっと貧しい開発途上国には、まったく学校に行けない女性たちは少なくありませんし、5歳になる前に死んでしまう子どもたちはたくさんいます。この女性は、近くの公立診療所の看護婦にいつでも相談できますが、他の多くの開発途上国では、妊娠・出産の際に医師や看護婦に診てもらうこともなく命を落とす女性たちが後をたちません。

このように、人々の健康は、その社会の状況と深く関連しています。まず、貧困のため起こる健康の問題はたくさんあります。貧しい国々、たとえば南アジアやサハラ以南アフリカの国々などでは、子どもたちの約半数が栄養不良状態に陥っており、下痢症や肺炎など予防できる病気で命を落としています。医療体制の整備は遅れ、公立診療所があっても、医師がいなかったり必要な薬剤がなかったりします。

また、経済開発を進めたとき、そのひずみが人々の健康に悪影響を及ぼすことがあります。タイの例のように、都市と農村の経済格差が拡大した結果、農村から都市に流入した人々が劣悪な環境のスラムで生活して健康を害することなどがあげられます。さらに、急速に社会情勢や経済状況が転換したとき、人々の健康は影響を受けます。たとえば、共産主義体制崩壊後のロシアでは、平均余命がかえって短くなってしまいました。

人々が病気になる時、細菌感染などの直接的要因、栄養状態が悪くて抵抗力がないなどの間接的要因に加えて、貧困や社会慣習などの経済的・社会的・文化的要因が遠隔的に作用しています。遠隔的要因の一つが、ジェンダー (社会的・文化的性別) です。女性が、社会的弱者の立場に置かれ、生活や行動を著しく制限するような文化や慣習に従わねばならないために、健康問題を起こすことがあります。女性は家族の中での食物配分があとまわしになったり、病気になっても夫の許しがなければ病院に行けなかったりするなどの例が、世界各地で認められています。

健康の問題は、医学・医療が発達しさえすれば、あるいは、人々が豊かになりさえすれば解決できるわけではありません。ジェンダーをはじめとする社会的・文化的側面を、十分考慮にいれた対策が必要なのです。

『開発と健康』

第2回

紛争後復興と女性の健康

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アフガニスタンに、ようやく待ち望んだ春が来ました。日毎に暖かさを増す首都カブールの繁華街の大通りには、日本製中古車や黄色いタクシーがあふれ、中国製の自転車が行きかっています。顎髭を短く刈り込み、民族衣装姿か、ぎこちなく洋服を着こんだ男性たちに混じって、ブルカと呼ばれる全身をすっぽり隠す青い外套を身にまとった女性たちが、雑踏の中を歩いています。タリバン政権下で家庭に閉じ込められていた女性たちが、今、どんどん家の外に出ているのです。今後、政権が安定し治安が確保されれば、女性たちはブルカなしで街を歩くようになるのだろうと思いました。

アフガニスタンは、東西文明の十字路として栄え、18世紀に王制確立、帝政ロシアやインドを支配したイギリスにも抗しました。1973年、国王が追放され共和制に移行、親ソ連路線をとりましたが、国内反対勢力が強まって、1979年にソ連軍侵攻、反対派ゲリラとの戦闘が続きました。1989年のソ連軍撤退後も、ゲリラ各派間で内戦が続き、首都カブールは戦場となりました。イスラム原理主義学生軍団タリバンは、1996年にカブールを掌握、国土の8割を実効支配しました。2001年9月、ニューヨークでテロ事件発生、アメリカは、テロリストが潜む場所としてアフガニスタンを攻撃し、タリバン政権を崩壊させました。2001年12月、アフガニスタン暫定政権が発足、2002年4月、元国王は29年ぶりに祖国の土を踏みました。

20年以上にわたる内戦とタリバンの原理主義政策によって、アフガニスタンの女性たちは持っていたものの多くを失いました。多くの人々が家や職場、家族の誰かを失い、保健医療・教育をはじめ社会の基盤となるシステムは荒廃しました。夫を紛争で失い、教育も職もない貧しい女性たちは、国際機関などの食料支援に頼って細々と命をつなぐしかありませんでした。1974年に出生10万対690だった妊産婦死亡率は、世界最悪の水準である1,700にまで悪化、生まれてきた子どもたちの4人に1人が5歳になる前に死んでしまうという状況に陥っています。

一般に、紛争の影響が最も甚大であり、難民の大部分を占めているのは、女性と子どもです。難民キャンプでは、一部の男性が物資の配分を決めてしまうことがあり、女性と子どもだけの家族は、栄養・健康状態に問題があることが多いのに、必要な援助を十分に受けられないことがあります。また、逃げて来る途中やキャンプで、女性たちは、さまざまな暴力の危険に常にさらされています。

紛争によって、女性たちの教育や就業の機会は大きく妨げられます。紛争が終結しても、社会状況は混乱し、帰還兵士はじめ職を求める人々があふれ、女性たちが収入を得るのは容易ではありません。さらに、紛争を直接体験してきた女性たちの心には大きな傷が残り、紛争が終わり身体の外傷が癒えた後も心身の不調が続くこと（心的外傷後ストレス障害／PTSD）があります。外見上、復興が進んでも、人々の心に傷が残ると、それが次世代にも影響して、新たな紛争の火種となることも考えられます。

紛争後地域は、多くの場合、政治・社会状況がきわめて不安定で、将来の予測が困難です。しかし、復興開発には、緊急の生活支援などとあわせ、中長期的展望のもとに、社会基盤整備や保健医療・教育など社会システム再建を進めなくてはなりません。保健医療プログラムなどを進めることは、社会不安と紛争の悪循環を絶ち、平和を構築するきっかけとなることも期待できます。

誌上講座『開発と健康』

第3回

開発途上国のリプロダクティブ・ヘルス

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カンボディアに雨季がやってきました。豊かな恵みをもたらす雨ですが、土地の低い地域一帯が水浸しになってしまうこともよくあります。仕事ができなくなったり、衛生環境が悪化したりして、貧しい人々が、さらに貧しく不健康になってしまいます。

首都プノンペンの隣の県にある村を訪れた時、35歳になる女性から話を聞きました。このところ夫の日雇い仕事がなくて、親戚から日々の生活費を借りているそうです。学校に行ったことはなく読み書きもできません。子供は6人で、15歳にしては小柄な一番上の男の子が、かいがいしく弟妹の面倒を見ています。生後5ヵ月になる末っ子が生まれるまでは、彼女も果樹園に雇われていたそうですが、今は働くこともできないそうです。以前、妊娠中に池に落ち、双子を早産して亡くしましたし、他の子の出産後には、身体がしびれたようになったこともあったそうです。家族計画の方法についてよく知らないと言い、とくに望まないのに妊娠を繰り返してきました。子供が増えて生活はどんどん苦しくなってくる、収入のないことを責めると夫にいつも殴られる、と話してくれました。

カンボディアは、もともと母親を大切にする文化のあるところと言われていますが、妊産婦死亡率はきわめて高く、なかなか改善しません。内戦の後遺症、貧困と、教育水準の低さが絡み合い、この国の女性の健康を損ねる要因となっています。国際社会に復帰してようやく10年、豊かになった人々もいますが、多くの貧しい人々は依然として貧しいままです。女性たちの多くは、妊娠中に検診を受けることなく、医師や助産師の介助なしに自宅で出産します。難産や大出血になっても、母子の命を救える病院は数少ないうえ、救急搬送のシステムもありません。

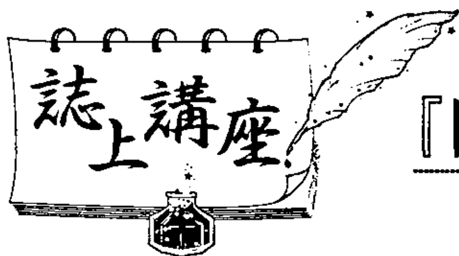
妊娠出産に関連して女性たちの生命が危険にさらされることは、カンボディアに限らず、世界中の開発途上国で日常的に起こっています。現在、世界中で毎年585,000人の女性が、妊娠出産が原因で命を落としていると推定されています。そのうえ、妊娠中や出産時の状態が悪いことが原因に

なって、毎年300万人以上の新生児が死んでいます。

家族計画は、産科医療体制が不備な開発途上国で、女性たちの命を救うのに有効な対策の1つです。非合法の危険な妊娠中絶によって女性が死んでしまうのを防ぐことができるばかりでなく、妊娠と合併症発生の絶対数を減らして、妊産婦死亡数を減少させることが期待できます。さらに、出産間隔を2年以上とすることによって、開発途上国における妊産婦・乳児死亡の4分の1 が予防可能と考えられています。

貧しい開発途上国では、安全な妊娠・出産と家族計画の普及が、保健医療分野の重要課題であり、現在では、リプロダクティブ・ヘルス(性と生殖に関する健康)という概念に包含されています。リプロダクティブ・ヘルスは、1994年のカイロ国際人口開発会議以来、国際的に認知された概念です。具体的には、妊娠・出産、家族計画、不妊、性感染症、乳癌・婦人科癌、思春期保健、更年期保健、男性の健康と役割、女性に対する暴力など広範な内容を含みます。

リプロダクティブ・ヘルスの改善は、先進国・途上国を問わず重要ですが、とくに貧しい開発途上国では、女性たちの命を守ることに直結します。文化的・社会的制約などにより、女性の健康改善が立ち遅れている地域はまだ多いですが、こうした地域でも、女性の健康を守る活動を地道に続けていかなければなりません。



『開発と健康』

第4回

人々の健康を守るために

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青山　温子

カンボディアの雨季も終わりが近づいてきました。まだ夕方時々、雨がひどく降ったりしますが、昼間の陽射しは暑く肌をさします。メコン川の船着場では、冷やしたコーラの缶をバケツにいれた売り子たちが、フェリーを待つ車の窓を覗きこんできます。フェリーはほんの数分間で川を越え、車はさらに走り続けます。暗くなってからようやく、ヴィエトナムとの国境に近いスヴァイリエン県につきました。

県病院では、夜勤の医師が熱心に説明しながら案内してくれました。この病院では、国際機関の技術支援を受け、診療収入を確保して病院運営に活用するシステムをつくりました。暗い病室には、帝王切開手術後の女性が、マットすらない硬いベッドに横たわっていました。ハンモックで2時間担がれてこの病院にたどりついたのだそうです。付き添いの母親は、小さな小さな生まれたばかりの孫を抱いて、この病院にはとても満足していると話してくれました。

翌朝、こんどは、保健センターのスタッフが村に出かけて予防接種をしている様子を見学しました。車の幅より狭いぬかるんだ道をすり抜けて村の広場に到着すると、高床式の建物の下に、母親たちや子どもたちがたくさん集まっていました。母親に抱かれた乳飲み子に予防接種するのは保健センターの看護師、ビタミンAを飲ませているのは村の保健ボランティアでした。母親にも新生児破傷風を予防するワクチンを接種し、一緒に来ている少し大きい子たちには駆虫剤を飲ませていました。ワクチンや薬は日本政府が寄贈したもので、国際機関が技術的な支援をしていました。

開発途上国の保健医療分野には、たくさんの課題があります。下痢症や感染症ばかりでなく、循環器疾患や外傷などに苦しむ人々もたくさんいて、平均寿命が60歳に満たない国もまだ多くあります。また、病院が遠くて交通手段がなかったり、貧しくて診療費が払えなかったり、安い公立病院には必要な薬や医療機材がなかったり、医師や看護師などの技術水準があまりにも低かったりして、命を救えるような病院を受診することさえ容易ではありません。一時的によい保健医療が実現できても、コスト負担をどうするかという対策を考えないと、長く継続することはできません。

保健医療分野のさまざまな課題に取り組む戦略として、二つの柱があります。ひとつは、公平で効率的で質のよい保健医療を提供できるシステムを作ることです。病院を中核とした地域医療システム、医療保険制度、医療情報システムなど、いろいろなシステム・制度を確立していくことが必要です。もう一つは、予防・公衆衛生活動を充実させることです。予防接種、母子保健、健康教育など、あまりお金のかからない方法で、多くの人々の命を救い健康を改善することができます。

しかし、このような活動をすすめようとしても、開発途上国には技術も資金も不足しているため、国際機関や先進国の援助機関、非営利民間団体（NGO）などが、いろいろな支援をしています。最初にのべた、病院の運営や予防接種活動にも、国際機関や日本政府などが援助をしていました。

健康を守るために最も大切なことは、人々が自ら主体的に健康改善に関わっていくようになることです。国際機関や先進国の援助機関は、貧しい国の人々が、少しずつ自立していけるよう手助けをしているにすぎません。とくに、女性たちは、子どもや家族の健康を守るのに重要な役割をはたすことが多いため、女性が健康に関する知識を身につけて積極的に関わっていくことは、きわめて大切です。

世界水準の国際協力

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名古屋大学医学部卒、同大学院医学研究科修了、医学博士。基礎医学研究・産婦人科臨床に従事後、1992年より現在の国立国際医療センター国際医療協力局に所属、保健医療分野プロジェクトなどにかかわった。96〜99年、世界銀行本部中東・北アフリカ地域担当の保健医療専門家として勤務。2001年より現職。著書に「開発と健康―ジェンダーの視点から」（有斐閣）など。

2002年6月、ワールド・カップに日本中が沸き立ち、人びとの心にさまざまな余韻を残した フランス人監督率いる日本代表チームでは、外国で活躍してきた選手と日本で頑張っている選手たちが、共通の目的に向かって力を合わせた。サッカーには素人だが、日本チームの善戦の要因を考えたとき、開発援助・国際協力の視点からも示唆に富むように思われた

異文化社会に身をおき、技術ばかりでなく考え方や姿勢を伝えてきたという点で、トルシエ監督は、開発援助専門家に相当するといえよう。トルシエ氏が日本人選手を初めて指導したとき、技術はあるのに戦う気持ちが不足していると感じたとのことである 開発途上国にはきわめて優れた人材が少なくないのに、全体としてうまく機能していない。その理由を考えると、個々の人材の技術や知識を向上させることばかりでなく、その根底にある考え方や、その国全体の底上げに結びつける姿勢を伝えることこそが重要であると理解される

外国で活躍してきた選手たちは、国際レベルの競争の厳しさに触れた経験を日本チームにもたらした。日本にもよい選手たちはいるが、世界水準を実感した者にしか本当の意味で日本の実力を理解することはできず、この選手たちなくしては、日本チームがここまでレベルアップすることはなかっただろうと思われる 他方、外国で活躍できるほどの選手がいるということは、日本で選手を育成する体制が整ってきたことを反映している

日本の開発援助を、国際社会から高く評価される水準に引き上げるには、国際機関やほかの援助機関で経験を積んだ人材が、もっと参加するべきではないかと思われる また、日本の開発援助で育った人材に、国際機関で働いたり留学したりする機会を与えていくことも必要である 私も、保健医療分野の専門家として日本の開発援助にかかわった後、世界銀行という国際組織で外国人たちと一緒に働いてきた。国際機関での経験から、あらためて日本の開発協力のあり方を考えさせられた

外からみたとき、日本の開発援助が良いプログラムを実施しているのに、国際社会から十分に認知されていないことがあるのに気づく その原因の一つとして、プロジェクト形成の際、世界的潮流を理解し対象分野が属するセクター全体を見渡して優先課題を把握する、という作業が十分なされていないことがあると思われる その結果、特定の分野だけに限ってみればよいプロジェクトであったとしても、相手国の長期的セクター政策にうまく適合せず、国際社会からは十分認知されないことが起こり得る 世界的潮流やセクター全体を見渡す眼を養うには、国際機関での経験が役立つと考えられる

また、必要に応じて、日本の開発援助に、外国人の優秀な人材が参加できるようにしてもよいのではないだろうか 日本人の不足する分野に外国人専門家が参加すれば、専門家の育成にも役立つ 多国籍チームでは、それぞれの責任や役割分担を明確にする必要があり、専門家の活動評価がより適確にできるという利点もある

現状では、国際社会から認知される水準の日本人専門家はまだ不足している 世界水準の国際協力専門家が育つことは、日本の開発援助の将来にとっても重要であると思われる 善戦した日本チームにサポーターが惜しみない声援を送ったように、世界水準の国際協力に対しては、納税者からも強い支持が得られることであろう

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International Cooperation in Health and Medical Care

ETSUKO KITA

The global population now stands at more than 6 billion. These people are spread across over 190 countries, but only about 30 of these are industrialized with annual per capita incomes of over $10,000; their combined population is barely more than 600 million. In sub-Saharan Africa, meanwhile, which is home to about the same number of people, only Botswana, Gabon, Namibia, South Africa, and Swaziland have per capita incomes of over $1,000, according to the World Bank; in the more than 40 other nations in the region the equivalent figure is just a few hundred dollars.

Medical care is generally understood to be the application of specialist medical knowledge and techniques to cure illnesses afflicting individual people. But in order to provide good medical care anytime, anywhere, to anyone, on a long-term basis, large-scale systems are required. It is not enough simply to have doctors and nurses with the necessary skills and hospitals and clinics with certain equipment. To treat a patient properly, there must be constant supplies of water, electricity, and gas; medicines must be transported and stored in the correct conditions; and the technology and infrastructure needed to produce and distribute glass, plastic, and other materials used in medical treatment must be available. There also needs to be a system for transferring patients between general hospitals and facilities offering advanced, specialist care. In recent years, while scientific and technological progress has enabled the development of highly sophisticated treatments, this has also led to a spiraling of medical costs. In industrial countries all possible means are available to treat each sick individual, the price for which in annual medical costs now runs to

several thousand dollars per person. The application of such a system to the less developed countries is clearly not a viable option at the present time.

Public health generally means systems of scientific knowledge and technology used to maintain, improve, or restore the health of whole social groups. In the field of international cooperation, however, the term refers to the health situation of a group as a result of the application of these systems. *International health*, the theoretical basis for cooperation in the fields of health and medical care, is a subdiscipline of public health that deals with how health problems relate to levels of economic development.

Poorer countries have just as much need for medical care as the richer ones. But it is a fact that assistance for developing countries unable to provide costly medical care anytime, anywhere, to anyone tends to prioritize public-health-type measures to protect the well-being of large numbers of people for relatively little outlay. This is not just an issue of cost. The level of people's understanding of how to protect their own health is another important factor. Although exchanges of highly advanced technology among industrial nations can also be regarded as being part of international cooperation, here I will focus on health issues in developing countries.

HUMAN SURVIVAL AND HEALTH

Around 2,000 years ago the human population is thought to have been about 300 million. Not until the middle of the seventeenth century did the number of humans reach 500 million, and it took a further two centuries years before the 1 billion mark was breached. Leaving aside short-term, localized population spikes, from the time humankind first appeared until the modern age, the rate of population growth had never risen above 0.1%.

The Industrial Revolution transformed societies and individual lifestyles, however. Industrial development engendered new cities; advances in transport and telecommunication technologies empowered communities to overcome hunger; and progress in science, especially in medical knowledge and technology, enabled humans to understand the causes of epidemics and other states of ill health and to come up with countermeasures. Globally, humankind was able to tackle the roots of ill

health, such as hunger, infectious diseases, and poor sanitation, and people took charge of their own health. Population growth accelerated, and the 1 billion people of the nineteenth century became 2 billion in 1930, 3 billion in 1960, 4 billion just 14 years after that, and 6 billion by the end of the twentieth century.

Industrial development, ironically, has also brought new health risks. Urbanization led to the appearance of slums; people became exposed to harmful chemicals; and the environment was destroyed by exploitation and the release of pollutants. This has resulted in global warming and a drastic increase in droughts, floods, typhoons, hurricanes, and other natural disasters all over the world. These are problems whose solutions are beyond the scope of medical specialists.

Although it is in essence a medical problem, the emergence of HIV has changed basic assumptions around the world. HIV and AIDS are nothing more than a new virus and a disease caused by it, but prejudice against those afflicted has made it a human-rights issue; the link with the sex industry staffed largely by poor women has made it a gender and a poverty issue; the high rate of infection among younger age groups—those on whom the continued functioning of society depends—has made it an economic and development issue; and arguments over trade and intellectual property surrounding the use of expensive AIDS drugs have made it a cross-border issue. HIV/AIDS in developing countries is not so much a medical problem as a political and social problem on which the very survival of communities depends.

Other threats to the life and health of humanity that seem to be increasing worldwide include emerging diseases like the Ebola virus, E. coli O157, and bovine spongiform encephalopathy; reemerging, old diseases whose pathogenic organisms have acquired drug resistance like malaria and tuberculosis; and shortages and poor quality of water and food. On top of these, global warming is predicted to lead to such health problems as the spread of malaria.

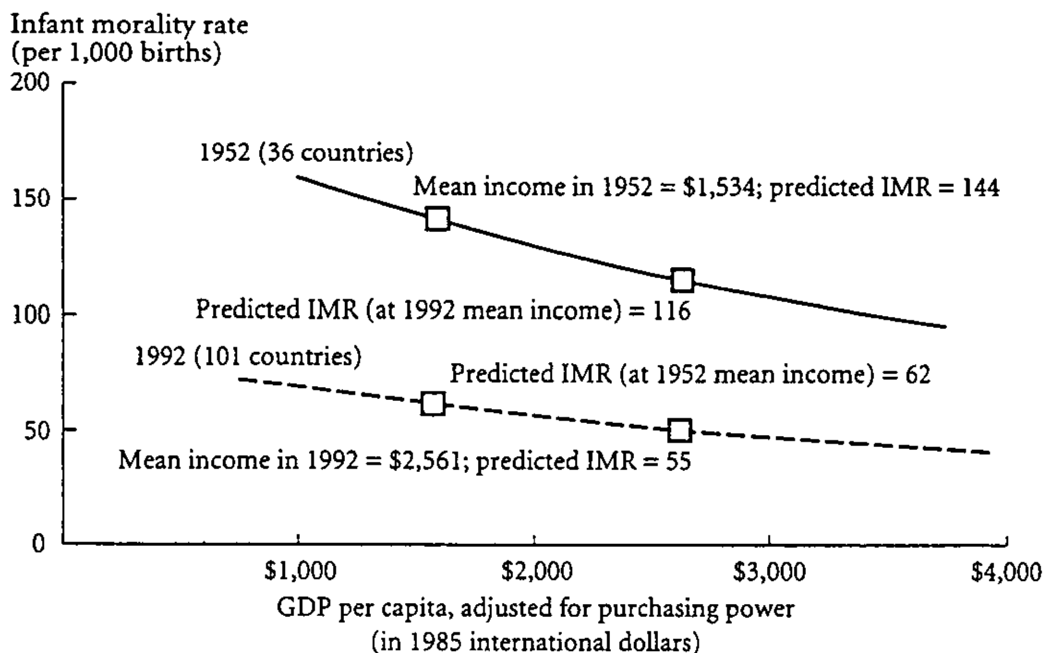
Furthermore, since the breakdown of the Cold War hegemony, there has been an increase in complex humanitarian emergencies around the world caused by conflicts over ethnic, religious, or other differences. CHEs are being viewed as a new form of man-made disaster in which conflicts are fought not between armies of professional soldiers but between ordinary citizens and in which even the safety of aid providers is sometimes

threatened. In industrial countries, meanwhile, major accidents involving jumbo jets and mass-transit systems are an ever-present danger. Terrorist acts involving highly destructive weapons or other unpardonable tactics may also be regarded as a kind of disaster. Inasmuch as such acts could lead to the loss of many lives, they relate to health and medical care and must also be approached from such angles.

One offshoot of globalization has been to accentuate the issues of poverty and health. The 1993 edition of the World Bank's annual report, *Investing in Health*, showed that the people who are most disadvantaged in health terms are those in absolute poverty (with income of less than $1 a day), many of whom are women. Since the health problems that affect the largest numbers of people cannot be solved without improving women's status and tackling poverty, these tasks now constitute a key aspect of development assistance in health and medical care. As Figure 1 shows, economic development helps to reduce infant mortality, but populations in developing countries, where many people are poor, continue to grow, and those in absolute poverty still account for about 25% of the human population.

In such circumstances, the focus of international cooperation in health

FIGURE 1
The Role of Improvements in Income in Reducing Infant Mortality Rates



Source: WHO, *World Health Report*, 1999.

and medical care should clearly be on public-health efforts conducted outside medical facilities, rather than on medical care in hospitals. Whatever means are chosen, the ultimate goal of these efforts must be to help people improve and maintain their physical and mental well-being, which is a basic human right. The respect of basic rights is indispensable for the development of a sound society, and harmonious social development is, in turn, indispensable for sound human physical, mental, and social development. Cooperation in health and medical care, therefore, is necessary not only to tackle health problems at the individual level but also to advance the development of local communities and nations and, by extension, to construct stable international relations.

COOPERATION OVER THE YEARS

In the past health and medical assistance provided to the developing world took the form of philanthropic or missionary work by benevolent figures like Albert Schweitzer and Mother Teresa or, as in the case of America's anticommunist activities in Indochina, formed part of efforts to curry favor with local populations. Later, in the 1960s, industrial nations sent food aid to Africa when it was gripped by drought and famine; around 1970 help was extended to victims of natural disasters, such as the massive cyclone that hit Bangladesh; and in the 1970s humanitarian assistance was provided to alleviate the by-then chronic plight of African refugees. These efforts sprouted official-development-assistance programs and international nongovernmental organizations. In particular, the realization that low levels of development and poverty often caused or exacerbated emergency situations convinced people of the need to shift from temporary humanitarian aid addressing the symptoms of crises to long-term development addressing the causes. In the health field, the recognition that the training of local residents and establishment of systems to deal with emergencies were of greater importance than medical care administered by outsiders led to the new concept of *community health.*

In the 1970s donors came to realize that their aid was not reaching those who truly needed it—the poorest people—and thus even in the fields of health and medical care, people began to focus increasingly on human-development and welfare indicators like infant and under-five mortality rates, average life expectancy, and literacy rates.

Basic human needs was the first expression of these ideas. First advocated by the U.S. Agency for International Development, BHN was subsequently adopted by the International Labor Organization and the World Employment Conference in 1976. Staying healthy is obviously a vital element in maintaining a minimum standard of living, and promoting good health subsequently became a cornerstone of international cooperation.

Primary health care has been the most noteworthy manifestation of BHN in the fields of health and medical care. In 1978 it was touted as a practical strategy for achieving the target of "health for all by the year 2000," which was established by the World Health Assembly in 1977. Unlike medical care, which treats individuals suffering from illness, PHC is a model that aims to involve individuals in their own health care and enable them to prevent illnesses and promote their well-being through their own efforts; it does not require advanced medical technology. The philosophy of PHC posits that promoting people's well-being is crucial not only for economic development but also for improving the quality of life of individuals, families, and communities. It implies that people should look after their own health and that reasonably priced health and medical services should be maintained through voluntary community participation. PHC is the first health service people are exposed to, and so it aims to become part of people's daily lives and to provide a constant level of services.

A practical PHC strategy requires the participation of local people, a targeting of needs, the effective use of resources, and cross-sectoral cooperation. It also encompasses such issues as (1) health education, (2) maternal and child health, including immunization and family planning, (3) environmental sanitation, especially food and water, (4) the employment of community health workers, (5) the promotion of nutrition, (6) the appropriate treatment of common diseases and injuries, (7) the prevention of local endemic diseases, (8) the provision of essential drugs, and (9) traditional medicine.

PHC should be seen not only as the backbone of a nation's health system but also as a pillar of social and economic development policies for particular regions, alongside such considerations as housing, transport, agriculture, telecommunications, and education. PHC still forms the basis for health-care efforts in developing countries, but it must be admitted that enthusiasm has waned somewhat among national governments and

FIGURE 2
The Rich-Poor Gap in Key Health Indicators

	Rich countries (A)	Poor countries (B)	B/A
Per capita income ($)	34,172	162	1/211
Under-5 mortality rate (per 1,000 births)	5.2	215	41
Infant mortality rate (per 1,000 births)	5.0	135	27
Average life span (years)	77.5	44.2	0.57
Literacy rate (%)	over 99	42.2	0.43
Total fertility rate	1.6	6.4	4
Maternal mortality rate (per 100,000 births)	6.3	785	124
Underweight newborns (%)	6.0	16.3	2.7

Source: UNICEF, *The State of the World's Children*, 2001.
Note: The "rich" and "poor" countries are the 10 countries whose per capita incomes were, respectively, highest (Australia, Belgium, Denmark, Germany, Japan, Luxembourg, Norway, Singapore, Switzerland, United States) and lowest (Burundi, Chad, Democratic Republic of Congo, Ethiopia, Malawi, Mozambique, Niger, Rwanda, Sierra Leone, Somalia) in 1999.

international organizations since the original goal of health for all by 2000 was not met.

The Expanded Program on Immunization, which has been conducted on a selective basis, is one successful manifestation of PHC. Following the eradication of smallpox, polio is expected to be eliminated soon. In many cases, however, a lack of knowledge on the part of parents, unhygienic environments, reduced resistance to disease due to malnutrition, and other factors have created conditions that are ripe for major outbreaks of tuberculosis, measles, polio, diphtheria, whooping cough, and tetanus—all children's diseases that can be prevented through immunization.

The health of large numbers of children has also been addressed by the United Nations Children's Fund (UNICEF)'s GOBI (growth monitoring, oral rehydration therapy, breast feeding, and immunization) strategy, but the issue of mothers' health was largely neglected. It was not until the 1990s that measures to improve women's health made progress.

As shown in Figure 2, the maternal mortality rate (the number of women who suffer pregnancy- or childbirth-related deaths per 100,000 births) is more than 120 times higher in the 10 poorest countries than in the 10 richest, an even starker discrepancy than that seen in the under-five mortality rate, where the equivalent figure is 41 times. According to revised estimates issued in 1996 by the World Health Organization and

UNICEF, the average maternal mortality rate in Japan was 8 between 1980 and 1998, while in Afghanistan it was 1,700, in Nepal 1,500, and in Bolivia 650. A simple comparison reveals that the risk of childbirth was 213 times higher in Afghanistan than in Japan, 188 times higher in Nepal, and 81 times higher in Bolivia.

The WHO reported that 585,000 women die around the globe each year from pregnancy and childbirth, including unsafe abortions. Several times more suffer from aftereffects or other problems. One in 50 women in developing countries dies from abnormalities, complications, or side effects of pregnancy or childbirth, compared with one in 2,700 in industrial countries. This shows just how hazardous pregnancy and childbirth can be for women in poor nations.

At the International Conference on Population and Development in Cairo in 1994 there was broad agreement on the need to reduce such deaths, expand reproductive health services to all regions, raise education levels among women, and push ahead with efforts to promote gender equality.

The concept of reproductive health covers much more than just mother-and-child health care. It aims to enable people to have the number of children they want, when they want them and to ensure that women can give birth safely without being threatened by illnesses of the reproductive organs, unsafe abortions, or sexually transmitted diseases like HIV/AIDS. One special feature of the ICPD was an agreement on the notion that the key to solving population problems is to give women more control over their lives, including childbirth. In particular, the international community publicly recognized for the first time that women's and mothers' health must be approached not just as a health and medical issue but as something inherently linked to the social environment in which women exist and that it requires a wide range of measures spanning a variety of fields.

At the Fourth World Conference on Women in Beijing in 1995, several problems were identified as common to poor urban households and rural families: food shortages, especially the fact that women do not get the same share of food supplies as men; a lack of access to safe drinking water, health facilities, and fuel supplies; poor housing; and health concerns stemming from the environment in which they live. It was pointed out that all of these problems place an excessive burden on women, threat-

ening their health. The Beijing conference's proposals on development were comprehensive and wide-ranging and aimed at improving the social status of and empowering women. The proposals included increasing the budget for social services and health care—in particular putting more effort into BHN in poor regions—and paying more attention to reproductive health.

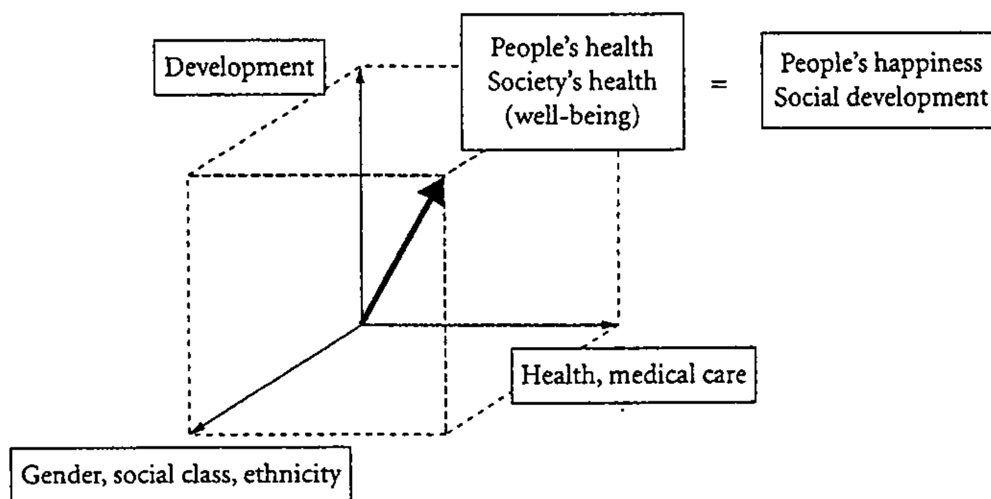
These currents are linked to the realization that gender is an inalienable aspect of development cooperation in health. As shown in Figure 3, it is impossible to achieve sound social development without efforts that address economic development, improvements in health and medical care, and issues like gender, ethnicity, and social class.

INDICATORS OF HEALTH

According to the WHO, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In developing countries, though, women who would be diagnosed as anemic by the standards of industrial nations and children who are clearly malnourished live quite normally; sometimes they are even engaged in heavy labor. What is the best means of measuring their health?

In the past, pediatricians were taught that the infant mortality rate re-

FIGURE 3
The Three Elements of Development



Source: Atsuko Aoyama, Hiroko Hara, and Etsuko Kita, *Kaihatsu to kenko* (Development and health) (Tokyo: Yuhikaku, 2001).

flected not only a country's health and medical standards but also how civilized it was. The IMR expresses the number of children per 1,000 births who die before their first birthday. Japan's rate was more than 150 until the Taisho era (1912–26), but it fell below 100 around 1940, to 30.7 in 1960, to 10 in 1975, and to 3.4—among the lowest in the world—in 1999. Moreover, Japan is one of the few nations where there are no major regional variations in infant mortality.

The health of a child in its first year of life is heavily influenced by the health and living standards of the mother during pregnancy and by the environment in which the child spends the time just after birth. Consequently, the IMR is thought to reflect the level of development of a given region, group, or country at a given time. *Life expectancy*, meanwhile, is the average number of years that survivors of a given age group will live, and *life expectancy at birth* is the average expected life span of newborn babies. Children who live past infancy have already overcome a period of major danger, and their chances of survival increase after that. However, afflictions that have largely been overcome in industrial countries—such as measles and other diseases that tend to affect children, acute respiratory infections like bronchitis and pneumonia, diarrhea, and malnutrition—are still major killers of children in developing nations. The under-five mortality rate proposed by UNICEF is often used to reflect the health situation of young children in these nations.

The finding that increases in female literacy rates are closely related to decreases in infant mortality—derived from data on numerous developing countries in the 1980s—raised interest in the issue of women in development, a concept that has since evolved into the twin ideas of women's empowerment and reproductive health rights. The indicators commonly used to gauge women's health are the total fertility rate (the average number of children women give birth to in a lifetime) and the maternal mortality rate. There are numerous other detailed indicators, but for getting a quick grasp of the state of health and health-related services in a given country, these two are the most useful.

THE FUTURE OF HEALTH COOPERATION

Comparing patterns in causes of death in developing and industrial countries as a whole reveals that while 93% of illnesses occur in developing na-

tions, just 11% of total global health and medical spending is used to treat them. In developing countries, one-third of all deaths are caused by infectious diseases, and more than 14 million children lose their lives to infectious diseases and malnutrition every year. This is equivalent to about 40,000 deaths every day, or 1,600 deaths every hour, from afflictions that either do not occur in industrial countries or, if they do occur, do not claim large numbers of lives.

Such conditions are akin to those that existed before industrialization brought on major changes in the social structure, lifestyles, and disease patterns and are characterized by a vicious circle of poverty and the poor state of public health infrastructure. In industrial nations, meanwhile, most disease-related deaths are caused by chronic or so-called lifestyle illnesses, including malignancies, cardiovascular diseases, mental disorders, and arthritis. Knowledge of changes in the structure of disease stemming from this epidemiological transition and of the background to them is vital for those engaged in international cooperation, for in some developing countries, longer life spans and lower birthrates are making diseases normally associated with industrialized nations more prevalent.

Other factors that are complicating the task of improving the health situation in developing countries are the global HIV/AIDS epidemic; the spread of habit-forming substances like tobacco, alcohol, and narcotics; work-related accidents; new health issues like large-scale traffic accidents and pollution; and emergencies that can strike both industrial and developing nations, such as natural disasters, war, internal unrest, and terrorist attacks.

It is not only death but also the burden of disease that pose a major threat to developing countries' social development. Figures for disability-adjusted life years—an indicator that quantifies these effects and is useful in formulating health policies—show that infectious diseases account for 71% of lost DALYs in sub-Saharan Africa, while the equivalent figure in developing countries with established market economies is just 10%.

The health of the world's 6 billion humans is in a constant state of flux. *Health transition* is a term that encapsulates epidemiological changes and changes in the population structure. Estimates suggest that by 2020 noncommunicable conditions will account for 78% of deaths in developing countries. Those involved in international cooperation must be aware of the effect this transition will have on the health and medical needs of de-

veloping countries. Now let us look at the future priorities for cooperation.

In 1996 the Development Assistance Committee of the Organization for Economic Cooperation and Development published *Shaping the 21st Century: The Contribution of Development Cooperation*, which outlined the DAC's new strategy for improving the quality of life of all human beings. The strategy calls for the alleviation of poverty, for social and environmental sustainability and regeneration, for economic development through the participation of developing countries in globalization, and for a strengthening of the role of government in order to achieve these goals. Practical policies must be formulated to achieve the following health-related targets set by the DAC.

Infant Mortality The DAC's strategy states: "The death rate for infants and children under the age of five years should be reduced in each developing country by two-thirds the 1990 level by 2015." In countries where the under-five mortality rate is higher than 150 (32 out of 193 nations, with an average per capita income of $425, according to UNICEF's *State of the World's Children*, 2001), the key to improving children's health in the short term lies in PHC services aimed at preventing epidemics. Then, once the prospects look a little brighter, a realistic approach would be to shift the priority to quality control and standardization of PHC; measures to improve nutrition, health, and education for mothers and other women; and the introduction of advanced medical technology.

Maternal Mortality The DAC strategy calls for the rate of maternal mortality to be reduced by three-fourths the 1990 level by 2015, a significant pledge. Achieving this goal will be extremely difficult, however. For a start, maternal mortality statistics in developing countries are highly inaccurate. As long as pregnancy and childbirth are regarded as physiological phenomena that do not require medical attention and as long as most births—especially in rural areas—occur in the home and are unattended by trained health workers, the deaths of many newborns and even some mothers will continue to go unreported. Furthermore, there are many cultural and social factors that prevent women from receiving appropriate health and medical services, even if they feel unwell or appeal for help. It is vital that those engaged in international cooperation aimed at helping women take these cultural and social factors into consideration.

Reproductive Health Maternal mortality is where the health and medical gap between industrial and developing nations is widest. According to the DAC strategy, "Access should be available through the primary health-care system to reproductive health services for all individuals of appropriate ages, including safe and reliable family planning methods, as soon as possible and no later than the year 2015." It is vital that this target is met. The international community should make this goal a top priority for improving women's health, an area in which progress has been much slower than in children's health.

Future international cooperation—in whatever field—will be based not on the unilateral transfer of technology and knowledge from industrial countries that have these resources to developing countries that do not but on the understanding that taking appropriate measures to protect one's health is necessary for the sound development of the community to which one belongs and to the stability of international relations and is the moral responsibility of people around the world.

William Welch, who in 1916 founded the Johns Hopkins University School of Hygiene and Public Health to train health specialists for development—the oldest such institution in the world—said that raising hygienic standards in the community and improving people's health constitute major social investments. I would add that relying exclusively on economic indicators to assess health and education levels is unreasonable, for the outcome of improvements in these areas take time to appear; appropriate indicators to estimate progress in these fields should be proposed. Also, I would stress the importance of human-resources training to give people the knowledge necessary to undertake improvements by themselves in the highly complex fields of health and medical care.

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特集

地球社会の男女共同参画の推進に向けて

アフガニスタンの女性支援

坂東　まず、アフガニスタンの女性支援について、原先生からお話しいただけますでしょうか。

原　国際協力については、基本法や基本計画でも一応うたっているのですが、内閣府として具体的にどういう取組をするかについては明確でなかったと思います。そんなときに、官房長官から懇談会を開くとのお言葉があったので、できるだけのことをしたいと思って取り組みました。

坂東　懇談会では、5月31日に提言をまとめています。このときに、目黒先生が一番強調したかったことは何でしょうか。

目黒　ほとんど壊滅的状況から社会づくりをするときには、単なる経済復興ではなく、長期的にみて、全ての人の人権が同等に守られ、社会づくりに参画することが大切です。アフガニスタンでは、女性が極度に虐げられた状況でしたので、女性が男性と対等に社会づくりに関わっていくことが重要だと思ったわけです。

日本政府が「女性の地位向上」を支援の重要な柱としているのは大変心強いのですが、実態を見ますと、女性を対象とした個別プロジェクトという発想から抜け出していません。ジェンダーというのは領域横断的な視点ですから、あらゆる領域で女性がどのように力をつけるべきかを念頭に置いて考えました。ただ、アフガニスタンの実態を踏まえると、現状から女性たちが一歩でも前進することが重要です。このため、理想と現実の両面からまとめようというのが委員共通の認識でした。

坂東　アフガニスタンの現実ということでは、喜多先生はタリバーンの時代以前から、アフガニスタンとの関わりを持たれているわけですが。

喜多　1980年代にパキスタンでアフガニスタン難民援助に従事したときに、とても問題があることに気がつきました。その時の経験がこの懇談会にもいかせたかと思っています。

日本が国際協力の中で女性をターゲットにし、しかも内閣官房長官が率先して携わられたのが、とてもすばらしいことだと思います。そこに参加させていただいたことを大変光栄に思います。

しかし、現実を踏まえると、二つの問題があると思います。

一つは、このメッセージが、アフガニスタンの女性や男性に通じているのかということです。アフガニスタンの発展や安定を日本がとても真剣に考えているということを、絶えずアフガニスタン側に伝えていくことが必要ではないかと思います。